

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2012
NAME OF PROVIDER OR SUPPLIER REGIONAL HEALTH CARE PROFESSIONALS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 525-B W BRISTOL ST PO BOX 147 ELKHART, IN 46515		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<p>Initial Comments</p> <p>This visit was for a state home health complaint investigation.</p> <p>Complaints: IN00109448 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: July 16, 2012.</p> <p>Medicaid #: N/A.</p> <p>Facility #: 002407.</p> <p>Surveyors: Janet Brandt, RN, Public Health Nurse Surveyor</p> <p>Regional Home Health Care, Inc. was found to be in compliance with 410 IAC Article 17 Rule 12 Section 3 (4)(A)(B), Rule 13 Section 1(a), and Rule 14 Section 1 as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 19, 2012</p>	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1